Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Dependent Age 19 or Over Application for Coverage *Instructions*

YOU MUST COMPLETE THE ATTACHED FORM IN ORDER TO ENROLL YOUR DEPENDENT IN GIC COVERAGE IF THE DEPENDENT IS ELIGIBLE. If you do not complete the application, your dependent will have no GIC coverage.

Please keep in mind the following:

- Coverage for a dependent who is turning 19 ends on the last day of the month in which the dependent turns 19, unless the form is completed and returned to the GIC.
- Dependents who qualify as dependents under Internal Revenue Service (IRS) rules are eligible for coverage up to age 26 or two years after losing dependent status according to IRS rules, ***whichever occurs first***.
- For current insureds, continuous coverage will be allowed after the 19th birthday if the GIC receives a Dependent Age 19 or Over Application for Coverage within 30 days of the 19th birthday. Applications received at the GIC more than 30 days after the dependent's 19th birthday will have coverage beginning on the first day of the second month after receipt of the application.
- For new insureds, coverage for the dependent aged 19 and over will begin on the new insured's coverage effective date if he/she submits a completed dependent application before the insured's effective date of coverage. Applications received after the insured's effective date of coverage will be processed with a later effective date.
- Full-time student dependents must attend an accredited school.
- Dependents age 19 to 26 who are not full-time students or handicapped dependents may be eligible for continued coverage.
- You will be subject to imputed income on the full cost individual premium for the health plan in which you are enrolled for each Non-IRS Dependent covered under your policy.
- Fulltime students age 26 and over are not eligible for continued coverage if there has been a two year break in coverage with the GIC after the student has reached age 26.
- The GIC will determine coverage eligibility and effective dates.
- The insured must have family plan coverage.
- Your health plan or the GIC will contact you periodically to verify your dependent's continued eligibility. **IF YOU DO NOT RESPOND TO THESE VERIFICATION REQUESTS, YOUR DEPENDENT'S COVERAGE WILL BE TERMINATED.**

Instructions:

- If your dependent is a full-time student age 19 to 24, complete Sections 1 and 2;
- If your dependent is a full-time student age 24 and over, complete Sections 1, 2 and 4 **or** 5;
- If your dependent is mentally or physically incapable of earning his/her own living and has been so prior to age 19, OR became permanently and totally disabled on or after age 19 and is under age 26, complete Sections 1 and 3;
- A copy of the dependent's certified birth certificate is required for all new dependents.

INSTRUCTIONS CONTINUED ON OTHER SIDE

Dependent Age 19 or Over
Application for Coverage
Instructions (Continued)

You must notify the GIC when your dependent:

- Is no longer a full-time student at an accredited school;
- Withdraws from school;
- Is on a medical leave of absence from school or the medical leave of absence ends;
- Graduates
- Ceases to be an IRS dependent; or
- Ceases to be a Non-IRS dependent

Failure to do so may result in financial penalties.

If one of these events occurs and your dependent is eligible for continued coverage, you can apply for continued coverage by completing another "Dependent Age 19 and Over Application for Coverage", or you may apply for COBRA coverage.

- For clarification of Internal Revenue Service (IRS) rules for dependents, contact the IRS or a tax professional as they are the tax experts. Do not contact the GIC.
- We can only accept original applications, not photocopies or faxed transmittals. **Keep a copy of this application for your records.**

Questions?
617.727.2310
www.mass.gov/gic

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DEPENDENT AGE 19 OR OVER APPLICATION FOR COVERAGE

PLEASE PRINT AND ANSWER ALL QUESTIONS, SIGN THE COMPLETED FORM AND SEND IT TO THE GIC.

SECTION 1. INSURED/DEPENDENT INFORMATION

Name of Insured_____ Insured's Social Security #_____-_____-_____

Address_____Telephone Number (_____)_____

City/State_____ Zip code_____

Place of Employment_____

Name of Dependent_____ Dependent's Social Security #_____-_____-_____

Relationship to Insured_____ Dependent's Date of Birth_____/_____/_____

My dependent is one of the following *(check one and complete corresponding sections)*:

_____ Full-time student age 19 to 24 *(complete Section 2)*

_____ Full-time student age 24 to 26 *(complete Sections 2 and 4* ***OR*** *5)*

_____ Full-time student age 26 and over *(Complete Section 2; you will be charged the full cost premium for this coverage.)*

_____ Part-time student *(complete Sections 2, and 4* ***OR*** *5)*

_____ IRS Dependent Age 19 to 26 other than a full-time student *(complete Section 4)*

_____ Non-IRS Dependent Age 19 to 26 *(complete Section 5)*

_____ Handicapped dependent *(complete Section 3 and apply for coverage with a GIC Handicapped Dependent Application.)*

SECTION 2. STUDENT INFORMATION

The above dependent student has been accepted or is currently enrolled in the educational school listed below:

Name of Student's School *(Must be an Accredited School if Full-time Student)*_____

Address of School_____

City, State, Zip _____

Date Admitted _____/_____/_____ Expected date of graduation: Month_____ Year _____

Is your dependent student a full-time student? Yes _____ No _____

Is your dependent student a part-time student? Yes ____ No _____

Is your dependent student on a medical leave from school? Yes_____ No _____

If yes, please give dates of leave: From _____/_____/_____ To _____/_____/_____

I understand that I must notify the GIC when my dependent's student status changes (part-time to full-time, or full-time to part-time), withdraws from school, is placed on a medical leave of absence from school, returns from the medical leave of absence, or graduates. I also understand that my health plan or the GIC may, at times, verify my dependent's student status by contacting the school that my dependent attends. **Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the GIC's discretion**.

Signature of Insured _____ Date _____

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DEPENDENT AGE 19 OR OVER APPLICATION FOR COVERAGE *(continued)*

SECTION 3. HANDICAPPED DEPENDENT COVERAGE

My handicapped dependent named in Section 1 is either *(check one)*:

_____ mentally or physically incapable of earning his/her own living and has been so prior to age 19; OR
_____ permanently and totally disabled and became so on or after age 19 and is under age 26.

I understand that I must complete the GIC's *Handicapped Dependent Coverage* application, available from the GIC.

Signature of Insured _____ Date _____

SECTION 4. IRS DEPENDENT AGE 19 to 26 COVERAGE

My dependent named in Section 1 is a dependent under IRS rules. I have claimed or will claim him/her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) for the following calendar years ***(must answer for all three years):***

Calendar Year 2006 Yes ____ No _____
Calendar Year 2007 Yes ____ No _____
Calendar Year 2008 Yes ____ No _____

Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured _____ Date _____

SECTION 5. NON-IRS DEPENDENT AGE 19 to 26 COVERAGE

My dependent named in Section 1 is not a dependent under IRS rules, but I want to continue coverage for him/her up to age 26 OR two years after losing dependent status, whichever occurs first. I understand that there are income tax consequences to me. I have stopped or will stop claiming him/her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) for calendar year (please answer for all three years):

Calendar Year 2006 Yes ____ No _____
Calendar Year 2007 Yes ____ No _____
Calendar Year 2008 Yes ____ No _____

Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured _____ Date _____

SECTION 6. MAILING INSTRUCTIONS

Send completed application to: Group Insurance Commission, Continued Coverage Unit, P.O. Box 8747, Boston, MA 02114-8747

FOR GIC USE ONLY

Approved _____ Effective Date _____/_____/_____ Expiration Date _____/_____/

Denied _____ Reason _____

Reviewed by _____ Date_____/_____/_____